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Hospital Anxiety Depression Scale (HADS)

Availability:	**Please visit this website for more information about the instrument**: Please click here for the Hospital Anxiety Depression Scale
Classification:	Supplemental
Short Description of Instrument:	**Summary/Overview of Instrument:** The scale was designed to screen for mood disorders in general (non-psychiatric) medical outpatients. It is comprised of two subscales: Depression and Anxiety. It focuses on subjective disturbances of mood rather than physical signs, and aims at distinguishing depression from anxiety. Compared to other instruments scales, it focuses on emotional aspects of anxiety disturbances, as opposed to somatic and cognitive symptoms. **Construct measured**: Anxiety and depression. **Generic vs. disease specific**: Generic. **Intended use of instrument/ purpose of tool:** Clinical Trials, Observational Studies. **Means of administration:** Self- administered. **Location of administration:** Clinic, home, telephone. **Intended respondent:** Patient. **# of items:** 14 – Anxiety (7 items), Depression (7 items). **# of subscales and names of sub-scales**: 2 – Anxiety, Depression. **Special Requirements for administration:** None. **Administration time:** About 2-5 minutes. **Translations available:** Over 80 translations available.
Scoring:	**Scoring:** Items are rated on a 4-point Likert-type scale ranging from 0 t o 3, generating a scale range of 0 to 42 points, with higher scores representing greater symptom severity. The anxiety subscale has 3 items that refer to panic and 4 to generalized anxiety. Add the A questions to get a score for anxiety and the D questions for depression. Scores of 0-7 indicate normal levels of anxiety and depression; 8-10 indicate borderline abnormal anxiety and depression levels and 11-21 suggest abnormal levels of anxiety and depression. **Standardization of scores to a reference population (z scores, T scores, etc):** Not available. **If scores have been standardized to a reference population, indicate frame of reference for scoring (general population, HD subjects, other disease groups, etc):** Not available.

Psychometric Properties:	**Reliability:** Internal consistency described for patients with cancer (Moorey et al 1991): Anxiety subscale Cronbach's alpha = 0.93; Depression subscale alpha= 0.9. In healthy UK sample, internal consistency for Anxiety, Depression and Total scores were 0.82, 0.77 and 0.86 respectively (Crawford et al 2001). Test-retest reliability for healthy sample: correlation for Depression scale= 0.92; Anxiety subscale 0.89 (Snaith & Zigmond, test manual) **Validity:** Concurrent validity established in a number of studies (see Snaith & Zigmond, test manual). **Sensitivity to Change/ Ability to Detect Change (over time or in response to an intervention):** Not available. **Known Relationships to Other Variables:** HADS depression scores differentiate between patients taking/ not taking antidepressants, and male patients and older patents at time of diagnosis had higher HADS depression scores; HADS anxiety scores differentiated between patients with and without a psychiatric history and those taking/ not taking antidepressants (Wicks et al 2007). HADS Depression scores correlated with limb impairment, overall disease severity scores and, also with Anxiety scores with impairment on domains of the Sickness Impact Scale (Goldstein et al 1998). Anxiety and depression subscale scores correlated with subscales of the Sickness Impact Scale; Depression subscale scores correlated with speech and mobility scores on the Barthel Index and Anxiety scores correlated with Barthel speech items (Hogg et al 1994). **Diagnostic Sensitivity and Specificity, if applicable** (in general population, HD population- premanifest/ manifest, other disease groups)**:** Not available. **Strengths:** Serves as a good screening measure. Has been widely used. Relatively simple to complete. **Weaknesses:** This scale is not designed for HD; however, it is a quick screen. Requires insight to provide accurate reflection. No proxy verification.

References:	**Key Reference:** Zigmond AS and Snaith RP: The Hospital Anxiety And Depression Scale. *Acta Psychiatr Scand* 1983, 67:361-70. **Other References:** Crawford, J. R., Henry, J. D., Crombie, C. & Taylor, E. P. Normative data for the HADS from a large non-clinical sample. British Journal of Clinical Psychology 2001; 40: 429–434. Ferentinos P, Paparrigopoulos T, Rentzos M, Zouvelou V, Alexakis T, Evdokimdis I. Prevalence of major depression in ALS; Comparison of a semi-structured interview and four self- report measures. Amyotrophic Lateral Sclerosis 2011; Early online 1-6 Wicks P, Abrahams S, Masi D, Hejda-Forde S, Leigh PN, Goldstein LH Prevalence of depression in a 12-month consecutive sample of patients with ALS. Eur J.Neurol 2007; 14:993-1001 Goldstein LH, Adamson M, Jeffrey L, Down K, Barby T, Wilson C, Leigh PN The psychological impact of MND on patients and carers. J Neurol Sci 1998; 160(Suppl1) S114-121 Goldstein LH, Atkins L, Landau S, Brown RG, Leigh PN. Longitudinal predictors of psychological distress and self-esteem in people with ALS. Neurology 2006; 67:1652-1658 Olsson AG, Markhede I, Strang S, Persson LI. Differences in quality of life modalities give rise to needs of individual support in patients with ALS and their next of kin. Palliative and Supportive Care 2010; 8:75-82 Snaith RP. "The Hospital Anxiety And Depression Scale". Health Quality Life Outcomes. 2003; 1:29.